Submit this document to:
Crime Victims Compensation Program
Department of Labor & Industries
Post Office Box 44520
Olympia, Washington 98504-4520

CVCP INITIAL RESPONSE AND ASSESSMENT: FORM I

This form must be submitted if you are seeing the victim for **six sessions or less.** If you will provide more than six sessions, please complete Form II. *Payment is contingent on the detail provided in this form* and upon the processing and approval of the CVCP application for benefits.

Bill Procedure Code 0122C For This Report.

Victim's Name		Cvcp Claim Number
Family Member's Name (if counseling is for a family member of a sexual assault or homicide victim)		Date treatment began
Time Period this Report Covers (*from* month/day/year *to* month/day/year)		Date Form Completed
Clinician's Name	Clinician's Provider Number (if known)	Number of sessions to date
Clinician's Address		Clinician's Phone Number ( )
City		State Zip+4

Please review the CVCP guideline on Initial Response, Assessment and Documentation Procedures and provide answers to the questions listed below. You may copy and complete this form, or send a narrative report that contains all of the points listed below.

1) What is the victim's or caregiver's initial description of the crime incident for which they have filed a CVCP claim? If the victimization was not recent, please describe what brought the victim into treatment at this time.

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2) What are the victim's presenting symptoms/issues (by your observation and client report)?

3) Has the victim experienced time loss from work as a result of this victimization?

☐ No

☐ Yes; Please list the date(s) the person was unable to work and if applicable, give an estimated date of when the individual will return to work. Please explain why the time loss has occurred, the extent of impairment and the prognosis for future occupational functioning.

Dates:

Explanation:

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4) What type of intervention(s) did you provide?